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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARY OLIVER GALLAWAY** P.O. Box 1449 Choctaw, OK 73020 Registered Nurse License No. 575397 Respondent.	Case No. 2010-294 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant), brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board (Board) of Registered Nursing, Department of Consumer Affairs.

2. On or about December 27, 2000, the Board issued Registered Nurse License Number 575397 to Mary Oliver Gallaway (Respondent). The license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2010, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY / REGULATORY PROVISIONS

6. Code section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

" . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

7. Code section 2762 provides, in pertinent part, that in addition to other acts constituting unprofessional conduct within the meaning of the Nursing Practice Act, it is unprofessional conduct for a licensed nurse under this chapter to do any of the following:

" . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. California Code of Regulations, title 16, section 1442, defines "gross negligence," as used in Code section 2761, as "an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or

failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, defines "incompetence," as used in Code section 2761, as "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care

before it is provided."

COST RECOVERY

11. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable investigation and enforcement costs of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

12. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

13. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

14. "Vicodin" is a brand of hydrocodone bitartrate and acetaminophen, an analgesic compound qualitatively similar to codeine. It is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

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FACTUAL BACKGROUND

15. Between approximately June 15 and September 30, 2005, while working as a registered nurse in the medical-surgical unit at Kaiser Permanente Hospital in Santa Rosa, California, Respondent obtained Vicodin for patient administration by accessing the hospital's medication dispensing system (Pyxis), but did not document or otherwise properly account for the administration or disposition of the medication. On at least two occasions, the patient for whom the dispense was made was on PCA (non-oral) medication. In at least one instance, the patient for whom the dispense was made had an NPO (nothing by mouth) order. The circumstances are detailed as follows:

Patient K[1]

a. On or about June 15, 2005, Patient K, who had been administered morphine, had an 1130 NPO physician's order and a 1930 NPO physician's order until the effects of a spinal block wore off. At approximately 1505, Respondent documented administration to Patient K of Vicodin 2 tabs without a correlating dispense. At approximately 1601, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient K but did not document or otherwise properly account for the administration or disposition of the medication. .

Patient J

b. On or about June 22, 2005, at approximately 1957, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient J, who reported a pain score of 10 on a 0-10 rating scale with zero representing no pain. At approximately 2105, more than an hour later, Respondent documented administration of Vicodin 2 tabs to Patient J.

Patient A

c. On or about July 18, 2005, at approximately 2225, Respondent documented administration of Motrin and an evaluation at approximately 2300, including a pain score of zero on a 0-10 rating scale. At approximately 2247, Respondent dispensed Vicodin 2 tabs from the

[1] Patients are designated letters to protect their privacy; their names will be made available upon request during discovery.

hospital's Pyxis on behalf of Patient A, did not document or otherwise properly account for the administration or disposition of the medication.

d. On or about July 19, 2005, at approximately 2020, Respondent assessed Patient A and recorded a pain score of 7 on a 0-10 rating scale and dispensed Tylenol. At approximately 2038, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient A, did not document or otherwise properly account for the administration or disposition of the medication.

Patient H

e. On or about August 4, 2005, at approximately 2021, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient H, but did not document or otherwise properly account for the administration or disposition of the medication.

Patient G

f. On or about August 10, 2005, at approximately 2036, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient G, but did not document or otherwise properly account for the administration or disposition of the medication.

Patient F

g. On or about September 1, 2005, at approximately 1828, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient F, who was prohibited oral medication at the time. Respondent did not document or otherwise properly account for the administration or disposition of the medication.

Patient D

h. On or about September 3, 2005, at approximately 2235, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient D, but did not document or otherwise properly account for the administration or disposition of the medication. Patient D had received Vicodin 2 tabs from another nurse at approximately 2020; Respondent documented that Patient D reported a pain score of 4 on a 0-10 rating scale at 2110.

Patient E

i. On or about September 6, 2005, at approximately 1429, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient E, but did not document or

otherwise properly account for the administration or disposition of the medication.

Patient C

j. On or about September 16, 2005, at approximately 1652, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient C, who was prohibited oral medication at the time. Respondent did not document or otherwise properly account for the administration or disposition of the medication.

Patient B

k. On or about September 17, 2005, at approximately 2114, Respondent dispensed Vicodin 2 tabs from the hospital's Pyxis on behalf of Patient B, but did not document or otherwise properly account for the administration or disposition of the medication.

FIRST CAUSE FOR DISCIPLINE

(False Entries)

16. Respondent is subject to disciplinary action for unprofessional conduct under Code sections 2762, subdivision (e), and 2761, subdivision (d), in that she made false, grossly incorrect, or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and/or dangerous drugs, as described in paragraph 15, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence)

17. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761, subdivision (a)(1), in that she committed gross negligence and/or incompetence within the meaning of California Code of Regulations, title 16, sections 1442 and 1443 respectively, as described in paragraph 15, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 575397, issued to Mary Oliver Gallaway;

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2. Ordering Mary Oliver Gallaway to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 12/15/09

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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